DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165329	A. BUILDING _____ B. WING _____	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLEY SPECIALTY CARE	305 WEST THIRD BOX 10 KINGSLEY, IA 51028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 9.24.21 A recertification survey and investigation of complaints # 97805-C, #99408-C, and incident # 96144-I completed August 23-30, 2021 resulted in the following deficiencies. Complaint 97805-C was substaniated. Complaint 99408-C was substaniated. Self-Report 96144-I was not substaniated. See Code of Federal Regulations (42CFR), Part 482, and Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Kingsley Specialty Care Center** does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and staff interview the facility failed to provide privacy during toileting and privacy for a resident disrobing with her room door open for 2 out of 9 residents reviewed for privacy, (Residents #2 and #12). The facility reported a census of 30 residents. Findings include: 1. The Minimum Data Set (MDS) dated 6/3/21 revealed Resident #2 needed the extensive assistance of 2 with bed mobility, transfers, and toileting. The resident had diagnoses of cerebral infarction (stroke), abnormalities of gait and mobility, dementia without behavioral disturbance, and overactive bladder. The Brief Interview of Mental Status (BIMS) was 12 which indicated the resident had moderately impaired cognition.	F 550	**F 550 Resident/Rights** Resident #2 has since discharged related to regarding Dignity and staff waiting for response to enter after knocking. Current residents residing the facility have the potential to be affected. Current staff have been re-educated regarding treating residents in a dignified manner. Current staff have been re-educated regarding providing privacy when providing personal cares to include the door being closed the window curtains and privacy curtains id applicable. 3 resident interviews will be conducted to determine that residents are being treated in a dignified manner by the Department Managers weekly for four weeks then monthly times two months. Results of interviews will be presented to QAPI monthly for further recommendations of needed.	9/24/2021

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F 550	Continued From page 2 During observation on 8/25/21 at 11:25 AM when Staff I, Licensed Practical Nurse (LPN) entered the resident's room to administer oral medications Staff I found resident to be sliding out of her recliner and assisted her. During the assistance, resident reported she needed to sit on the commode in her room. The resident was transferred to sit on the commode with an EZ Stand used by Staff I and Staff J, Certified Nurse Assistant (CNA), assisting. The resident's body was visually exposed to the outdoors during the entire procedure since the curtain in resident's room was left open during the entire procedure. During the same observation, Staff I directed Staff J to change the resident's shirt because it was stained with dried food. Staff I left the room to get paper towels leaving the room door partially opened both when Staff I left and returned to the room. The facility Incontinence Care/Peri Care policy dated 1/15 revealed to screen the resident for privacy. In an interview on 8/26/21 at 2:26 PM the Director of Nursing (DON) reported she would expect staff to provide privacy for residents during toileting. 2. The MDS dated 7/1/21 revealed Resident #12 required the limited assistance of 1 with transfers, supervision of 1 to walk in room, and the supervision of 1 for toilet use. The resident's diagnoses included dementia with behavioral disturbance, delusional disorders, and cognitive communication deficit. The BIMS for Resident #12 was a score of 3 which indicated a severe cognitive impairment.	F 550		

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F 550	Continued From page 3 Observation on 8/26/21 from 8:17 AM to 8:44 AM revealed the door to the resident's room was open revealing the resident had moved her slacks down to her ankles and continued to adjust her slacks while Staff K, Staff E, a Certified Nurse Assistant (CNA), Staff D, and Staff F walked past the resident's room. Staff I, Licensed Practical Nurse (LPN) was at the medication cart in the hallway near the resident's room during the observation. At 8:33 AM during the observation the Director of Nursing (DON) was in the hallway and directed Staff E to assist the resident. In an interview on 8/26/21 at 8:44 AM, Staff E reported she assisted the resident with toileting. During observation on 8/26/21 at 1:54 PM, Resident #12 called out for help. Her call light was on the floor. In an interview on 8/26/21 at 1:55 PM, Staff F, Registered Nurse, reported the resident walked independently in her room and was independent with toileting. The resident's Care Plan revealed Resident #12 was independent with all ADL's. In an interview on 8/26/21 at 2:26 PM, the DON reported she would expect any staff member to either provide assistance to a resident disrobing or to report this to a staff member capable of assisting the resident in order to protect the dignity of the resident.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		

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F 580	Continued From page 4 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)	F 580	**F 580 NOTIFICATION OF CHANGES** Resident #34 have been interviewed regarding blood sugar parameters. Current residents have the potential to be affected. Nurses and medication aides were re-educated on parameters of all vitals to include blood sugars and the need to inform the provider Three resident charts will be audited weekly for four weeks then one monthly times two months to include Vitals parameters verifications with results of the audit forwarded to QAPI for further recommendations if necessary.	9/24/2021

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F 580	Continued From page 5 Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to notify the physician of abnormal blood sugar readings as ordered for 2 out of 3 residents reviewed, (Resident #34 and #85). The facility reported a census of 30 residents. Findings include: 1. According to the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/13/21, Resident # 34 scored 15 on the Brief Interview of Mental Status (BIMS) indicating intact cognition. The resident had a diagnoses of Diabetes, Covid-19, and congestive heart failure. The resident required extensive assistance with 2 staff for transfers, mobility, and dressing. Review of the Care Plan showed Resident #34 used insulin and to monitor for side effects such as; low blood sugar, headache, weakness, and sweating with a creation date of 2/4/21. Review of the Orders tab in the Electronic Health Record (EHR) showed the resident had an order to notify the Primary Care Physician if blood glucose was less than 70 or greater than 400, with a start date of 2/4/21. Review of the Blood Sugar Summary, showed a	F 580		

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F 580	Continued From page 6 blood sugar of 60 was taken on 8 /23/21 at 5:22 PM, a blood sugar of 68 was taken on 7/21/21 at 3:02 PM. Review of the Progress Notes showed a lack of documentation that the Physician was notified of the low blood sugar readings. 2. According to the MDS with ARD of 8/19/21, Resident # 85 scored 13 on the BIMS indicating intact cognition. The resident had a diagnoses of Diabetes, Covid-19, and hypertension. The resident required extensive assistance with 2 staff for transfers, mobility, and ambulation. Review of the Care Plan showed the resident used insulin and to monitor for side effects such as; low blood sugar, headache, weakness, and sweating with a creation date of 8/12/21. Review of the Orders tab in the EHR showed Resident #85 had an order to notify the Primary Care Physician if blood glucose was less than 70 or greater than 400, with a start date of 8/12/21. Review of the Blood Sugar Summary, showed a blood sugar of 69 was taken on 8 /21/21 at 9:24 AM, a blood sugar of 69 was taken on 8/21/21 at 7:37 AM. Review of the Progress Notes showed a lack of documentation that the Physician was notified of the low blood sugar readings. During interview on 8/29/21 at 1:03 PM the Director of Nursing stated she expects nursing staff to notify the physician of any abnormal blood sugar readings as ordered.	F 580		

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F 655 F 655 SS=D	Continued From page 7 Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.	F 655 F 655	**F655 Baseline Care plan** Resident #26 and #5 was not completed within the 48 hours this has been reviewed with the resident Current residents that are new admissions within the last 48 hours could be affected. MDS nurse, DON and all licensed staff were re-educated on the need for the baseline care plan to be in place within 48 hours and that the resident and or resident responsible party to be informed of this in writing. Three residents will be audited for the next two months for signs as and symptoms of infection with results of the audit forwarded to QAPI for further recommendations if necessary.	09/24/2021

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F 655	Continued From page 8 (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy and staff interview the facility failed to offer a baseline care plan to residents or their representative for 2 out of 13 residents reviewed, (Residents #5 and #26). The facility reported a census of 30 residents. Findings include: 1. The Care Plan Signature Page with dates from 12/10/20 through 8/04/21 revealed the baseline care plan for Resident #26 was not reviewed by the resident or her representative. In an interview on 8/24/21 at 3:25 PM, Staff I, Licensed Practical Nurse and Minimum Data Set (MDS) Coordinator, reviewed the resident's clinical record and storage areas in her office to locate information that a baseline care plan was offered to the resident or her representative. Staff I was unable to locate the document and reported that she did not offer a baseline care plan to the resident or her representative. 2. The Care Plan Signature Page with dates from 10/1/20 through 7/1/21 revealed the baseline care plan for Resident #5 was not reviewed by the resident or her representative. In an interview on 8/24/21 at 3:25 PM, Staff I, Licensed Practical Nurse and MDS Coordinator,	F 655		

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F 655	Continued From page 9 reviewed the resident's clinical record and storage areas in her office to locate information that a baseline care plan was offered to the resident or her representative. Staff was unable to locate the document and reported that she did not offer a baseline care plan to the resident or her representative. The Care Plan Process policy dated 1/15 revealed that the resident was to be given the opportunity to select and approve the specific plan of care before it is instituted.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656	**F 656 Develop/Implement Comprehensive Care Plans** Resident #5 Care Plan has been reviewed to include intervention implementation for all resident specific information to include high risk mediations such as diuretics. Care Plan has been updated. Residents that require the use of high risk medications that include diuretics have the potential to be affected. Clinical Staff have been re-educated regarding the need for high risk medications as interventions for the Care Plan. Three residents rooms and care plans will be audited for placement of safety devices including high risk medications for four weeks then monthly times two months. Results of the audit will be forwarded to QAPI for further recommendations if necessary.	09/24/2021

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F 656	Continued From page 10 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and chart review the facility failed to develop a comprehensive person centered care plan for 3 out of 15 residents reviewed, (Resident # 12, #19, and #5). The facility reported a census of 30 residents. Findings include: 1. According to the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/1/21, Resident #12 scored 3 on the Brief Interview of Mental Status (BIMS) indicating severe cognitive impact. The MDS showed the resident required limited assistance with 1 staff for transfers, was independent with bed mobility and eating. Resident #12 had diagnoses of edema, hypertension, and kidney disease. Review of the Order tab in the Electronic Health Record (EHR) showed Resident #12 had an	F 656		

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F 656	Continued From page 11 order for hydrochlorothiazide (diuretic) 25 mg one time a day, with a start date of 12/8/17. Review of the Diagnosis tab in the EHR showed the resident had a diagnosis of edema, with a creation date of 2/14/18. Review of the Medication Administration Record (MAR) for the month of August 2021 showed the resident was given hydrochlorothiazide 25 mg once daily from August 1st 2021 to August 28th 2021. Review of the Care Plan showed a lack of information about the use and monitoring for adverse side effects from the hydrochlorothiazide and lacked any information about monitoring the edema or care needed for the edema. The Care Plan policy dated 1/2015 lacked any documentation of high risk medications such as diuretics needing to be included in the person centered care plan. During interview on 8/29/21 at 1:08 PM the Director of Nursing stated use of a diuretic and edema should be included in the Care Plan. 2. The MDS dated 8/8/21 revealed Resident #19 needed the extensive assistance 2 with bed mobility, transfers, and toileting; the limited assistance of 1 with eating and that the resident had severely impaired vision. The BIMS score for Resident #19 was 9 which indicated a moderate cognitive impairment. The resident's diagnoses was blindness in the right eye and low vision in the left eye. The current Care Plan lacked any interventions	F 656		

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F 656	Continued From page 12 related to Resident #19's vision deficit. The Care Plan Process policy dated 1/15 revealed to provide an individualized comprehensive plan of care for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment and to develop care directives to maintain the optimum health status when dependent on staff for needs. In an interview on 8/29/21 at 1:16 PM, the Director of Nursing reported that this should have been care planned. 3. The MDS dated 6/16/21 revealed Resident #5 needed the extensive assistance of 1 with bed mobility, transfers, and toileting; the supervision of 1 with eating. The BIMS score for Resident #5 was 4 which indicated a severe impairment of cognition. The resident's diagnoses included dementia without behavior disturbance and Alzheimer's Disease. Record review revealed Resident #5 had an order for a psychotropic medication, Seroquel, with no Care Plan interventions in place to monitor the use of this medication. The Care Plan Process policy dated 01/15 revealed to provide an individualized comprehensive plan of care for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment and to develop care directives to maintain the optimum health status when dependent on staff for needs. In an interview on 8/29/21 at 1:16 PM, the	F 656		

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F 656	Continued From page 13 Director of Nursing reported that this should have been care planned.	F 656	**F 658 Professional Standards**	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record reviews the facility failed to meet professional standards by not administrating an as needed Lasix per results of weight for 1 out of 1 resident reviewed,(Resident #34). The facility failed to track the amount of fluids given to a resident on a fluid restriction for 1 out 2 residents reviewed (Resident # 9) and the facility failed to ensure a resident was not given a medication that was listed on their allergy list for 1 out of 15 residents reviewed, (Resident #33). The facility reports a census of 30 residents. Findings Include: 1. According to the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/13/21, Resident # 34 scored 15 on the Brief Interview of Mental Status (BIMS) indicating intact cognition. The resident has a diagnoses of Diabetes, Covid-19, and congestive heart failure. The resident required extensive assistance with 2 staff for transfers, mobility, and dressing. Review of the Orders tab on the Electronic Health Record (EHR) showed an order to give	F 658	Resident #34 orders for fluid restiructions per recommendations and MD orders. Resident #34 has been interviewed regarding the fluid restriction. Resident #34 has been assessed regarding weight, edema and lung sounds regarding medications being given outside the one hour parameter. Current residents that have a fluid restriction were reviewed due to potential to affect them. All nursing staff have been educated on the need to document and follow all fluid restrictions. Three residents will be audited weekly for four weeks then one monthly times two months to include administration of medications with results of the audit forwarded to QAPI for further recommendations if necessary. 09/24/2021	

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F 658	Continued From page 14 Furosemide 80 mg by mouth as needed for weight gain of 2 pounds or more in 1 day or 5 pounds in 1 week. Review of the Weight Summary Report showed Resident #34 to weigh 376.0 pounds on 8/22/21 and weighed 380.4 on 8/23/21 indicating a 4.4 pound weight gain in 1 day. The Resident weighed 387.2 pounds on 8/13/21 and 389.2 pounds on 8/14/21, indicating a 2 pound weight gain in 1 day. The Resident weighed 385.6 pounds on 8/6/21 and weighed 388.7 on 8/9/21, indicating a 3.1 weight gain in one day. Review of the Medication Administration Record for the month of August 2021 lacked any documentation that an 80 mg furosemide was given for weight gain. During interview on 8/29/21 at 1:03 PM the Director of Nursing (DON) stated she expects as needed furosemide for weight gain to be given as ordered. 2. According to the MDS with ARD of 6/18/21, Resident # 9 scored 15 on the BIMS which indicated intact cognition. The resident had diagnoses of Covid-19, kidney failure and congestive heart failure. The resident required limited assistance with 1 staff for dressing and transfers and was independent with eating. Review of the Orders tab in the EHR showed the resident to have an order for a fluid restriction of 2200 ml's per day. Nursing may give 220 ml's for all medication passes. Combined nursing and dietary may give 580 ml's during each meal. Resident gets 120 ml's each snack time.	F 658		

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F 658	Continued From page 15 Review of the current Care Plan stated Resident #9 had a fluid overload or potential fluid volume overload related to congestive heart failure and acute kidney failure. The resident will comply with diet and fluid restrictions daily. Review of the MAR for the month of August 2021 lacked any fluid tracking documentation. During interview on 8/24/21 at 2:58 PM the DON stated that the amount of fluids should be tracked on the MAR. DON looked at the MAR and stated, "Well I guess they are not, I will fix it". 3. According to the MDS with ARD of 8/12/21, Resident # 33 scored 11 on the BIMS which indicated moderate cognitive impairment. The resident had a diagnoses of Dementia, pain in left hip and hypertension. The resident required extensive assistance with 1 staff for transfers, ambulation, and dressing. Review of the Orders tab in the EHR showed the resident had an order for Tramadol 50 mg, 1 tablet every 6 hours as needed for severe pain for 5 days with an order date of 5/18/21. Review of the Allergy tab in the EHR showed Resident #33 had an allergy to tramadol with a date of 2/25/21 and a resolved date of 5/18/21. The pharmacy Admission Medication Review form stated Tramadol was listed as an allergy. Please clarify what her reactions were and if she should be taking this, dated by the pharmacist on 5/18/21. The form had noted a response from the provider stating; listed reaction is hypertension, if she has been getting without problems then please continue, dated 5/19/21.	F 658		

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F 658	Continued From page 16 Review of the MAR for the month of May 2021 showed Resident #33 was administered tramadol starting 5/20/21 through 5/23/21. During interview on 8/28/21 at 12:18 PM the DON stated she thought the resident was given tramadol at the Emergency Room (ER) and had no reactions so she could have it and resolved the allergy in her chart. Review of the Clinical Summary from the ER dated 5/18/21 showed the resident was given oxycodone 5mg on 5/16/21 and 5/18/21 not tramadol. During interview on 8/29/21 at 1:07 PM the DON stated that no medication should be given to a resident if it is listed as an allergy.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** Resident #2 have been assessed regarding the pericare provided. Current residents residing in the facility have the potential to be affected. Clinical staff have been re-educated regarding incontinent care and the complete process for completing incontinent care. Three resident will be audited weekly for four weeks then one monthly times two months to include incontinent care with results of the audit forwarded to QAPI for further recommendations if necessary.	09/24/2021

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F 690	Continued From page 17 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, record review, and staff interview the facility failed to provide adequate cleaning for an incontinent resident for 1 out of 1 resident reviewed, (Resident #2). The facility reported a census of 30 residents. Findings include: The Minimum Data Set dated 6/3/21 revealed Resident #2 needed the extensive assistance of 2 with bed mobility, transfers and toileting. The resident had diagnoses of cerebral infarction (stroke), abnormalities of gait and mobility, dementia without behavioral disturbance, and overactive bladder. The Brief Interview of Mental Status score was 12 which indicated moderately impaired cognitive status.	F 690		

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F 690	Continued From page 18 During observation on 8/25/21 at 11:25 AM Resident #2 used the commode in her room. Staff J, Certified Nurse Assistance (CNA) removed resident's incontinence brief. The incontinence brief had a yellow color on the inside. When the resident completed the use of the commode, Staff I provided peri care to Resident #2 using a new surface of the wipe with each area of skin cleaned. Staff I did not clean all areas of skin covered by the incontinence brief including the sides of the resident's body before a new incontinence brief was applied. Resident #2's current Care Plan included she is frequently incontinent of urine and had a history of urine infection with a risk for skin breakdown. The resident's goal was to remain free of complication related to skin integrity. The Care Plan also revealed that she wore adult briefs at all times. The Incontinence Care/Peri Care policy dated 1/15 revealed that all soiled areas will be cleansed front and back. In an interview on 8/26/21 at 2:26 PM, the Director of Nursing (DON) reported that she would expect staff to clean all areas of skin that were under a soiled incontinence brief.	F 690		
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		

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F 695	Continued From page 19 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to provide tracheal suctioning for 1 out of 1 resident with a trach reviewed (Resident #25) which resulted in immediate jeopardy to resident health and safety. Resident #25 was admitted to the facility on 5/5/21 and had a capped tracheostomy in place. The resident was non-verbal and unable to make her needs known. The resident came to the facility with tracheostomy care orders for twice a day and to have tracheostomy suctioning as needed along with oropharyngeal suctioning as needed. The facility did not provide any tracheostomy suctioning from 5/6/21 to 8/18/21. The resident was sent to the emergency room (ER) on 8/18/21 after staff noticed gurgling sounds coming from the resident who had thick green/gray mucus in the mouth and a large amount of brown/yellowish mucus was coming from the tracheostomy. The resident was admitted to the hospital with a diagnosis of pneumonia and was placed on a ventilator. Findings include: The Minimum Data Set (MDS) with an Assessment Reference Date of 8/13/21 for Resident #25 showed the resident had a Brief Interview Status Score of 12 which indicated moderate cognitive impairment. Resident #25 had diagnoses of paralytic syndrome following cerebral infarction, encounter for attention to tracheostomy, aphasia following cerebral infarction, dysarthria following cerebral infarction,	F 695	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** Resident #2 have been assessed regarding the pericare provided. Current residents residing in the facility have the potential to be affected. Clinical staff have been re-educated regarding incontinent care and the complete process for completing incontinent care. Three resident will be audited weekly for four weeks then one monthly times two months to include incontinent care with results of the audit forwarded to QAPI for further recommendations if necessary.	09/24/2021

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F 695	Continued From page 20 and respiratory failure. The MDS showed the resident was totally dependant of 2 staff assist for transfers, locomotion, and toilet use. Review of the Patient Summary from the Hospital dated 3/22/21 stated on 2/20/21 Resident #25 developed worsening symptoms and became unresponsive. The patient was unable to protect her airway and was intubated on 2/20/21. The patient had ongoing difficulty with dysphagia and handling her own secretions. A tracheostomy was placed on 2/26/21 due to need for long term mechanical ventilation. Review of the Physician Progress Note from the Hospital dated 5/3/21 at 1:57 PM stated the resident had a capped tracheostomy and has thick oral mucus secretions, still requires suctioning and quite a bit of drooling which has improved. No apparent gag reflex noted with suctioning. Plan: no plans for decannulation until neuro status improves, still requires a bit of suctioning and having some drooling, added a abdominal binder for cough and vocal support. Review of the Physician Progress Note from the Hospital dated 5/4/21 at 11:25 AM stated physical exam showed thick oral mucus secretions, still requires suctioning, some drooling, and no noted gag reflex with suctioning. Plan: still requires suctioning, having some drooling. Review of the Electronic Heath Record (EHR) showed the resident was admitted to the facility on 5/6/21 from the Hospital. Review of the Transfer/Discharge/Active Orders from the Hospital with a faxed date of 5/5/21 at 11:59 AM, showed the resident to have Discharge	F 695		

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F 695	Continued From page 21 Nursing Orders for tracheostomy care every day at 8:00 AM and 8:00 PM, for respiratory therapy orders, to continue oropharyngeal suctioning as needed, and to continue tracheostomy suctioning as needed. Review of the facilities Admission Orders signed on 5/7/21 by receiving Nurse Practitioner state oropharyngeal suctioning as needed for secretions, tracheostomy care; cleanse with normal saline and apply gauze twice a day for trach care, and for tracheostomy suctioning as needed. Review of Resident #25's current Care Plan showed the resident was unable to care for the tracheostomy, the trach was a capped trach and to perform trach care every shift. Review of the Treatment Administration Record for the months of May 2021, June 2021, July 2021 and August 2021 lacked any documentation of oropharyngeal or tracheostomy suctioning. Review of the Speech Therapy Treatment Encounter Notes dated 5/7/21 stated to see initial evaluation. Initial Evaluation dated 5/7/21 stated findings included resident to have poor coordination of respirations with phonation, tracheostomy present with cap. Risk factors were, due to documentation of physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for pneumonia, social isolation, and aspiration. Further testing with fiber optic endoscope evaluation of swallowing (FEES) is indicated. Review of the Speech Therapy Encounter Note	F 695		

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dated 5/17/21 stated the Speech Language Pathologist (SLP) participated in the FEES evaluation, patient demonstrated aspiration with all consistencies. The SLP provided education to the patient and the skilled nursing facility (SNF) staff regarding risk for aspiration, pneumonia due to aspiration of secretions. SLP discussed concerns of need for staff training for deep suction. Note dated 5/24/21 stated the patient demonstrated significant wet vocal quality and coughing throughout the session. The SLP spoke with the DON requesting that the patient receive deep suctioning as soon as possible and regularly following the episode of care. Note dated 5/26/21 stated the patient demonstrated significant wet vocal quality and coughing throughout the session. The SLP spoke with the Nurse Practitioner regarding concerns that the patient needed suctioning.

The Progress Note dated 5/25/21 at 10:30 AM stated the DON contacted the Nurse Practitioner (NP) about the Speech Therapies concerns with the resident's lungs and suctioning. The NP stated she would see the resident on 5/26/21.

Review of the Physician Progress Note dated 5/26/21 at 11:00 AM stated a referral was made for an Ears Nose Throat (ENT) consult by the Nurse Practitioner.

The EHR lacked any documentation that an ENT consult was made.

Review of the Speech Therapy Encounter Note dated 5/31/21 stated the Speech Language Pathologist (SLP) the SLP focused on oral care, there was significant signs and symptoms of aspiration observed with secretions throughout

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the entire session. The SLP noted that the nursing staff at the facility had wanted to pursue removal of the tracheostomy.

Review of the FEES Evaluation Report dated 5/17/21 stated upon insertion of the scope, noted significant edema of the larynx and poor management of secretions were observed.

During interview with SLP on 8/24/21 at 9:09 AM the SLP stated when she was at the facility on 5/7/21 the suction equipment was sitting in box in Resident #25's room. She stated that staff made the comment they were not prepared to take this resident and the corporation pressured them into admitting her. The SLP stated while at the facility on 5/17/21 the suction supplies were still sitting in box in the same place. The SLP asked the staff if they could set up the suction equipment as they were going to be conducting the FEES test and wanted the suction in place for safety reasons. The SLP stated the staff told her they would have to watch a U-Tube video on how to set it up. The SLP stated she talked with the DON after the study and informed her of her concerns with the lack of suctioning and the need to provide training to the staff. The SLP stated on her visit to the facility on 5/24/21 the suctioning equipment was in the box again in the same place, she stated that once again she talked to the DON about her concerns with the lack of suctioning. The SLP stated while she was in the building on 5/26/21 she informed the NP who was in the building about the concerns of the lack of suctioning. The SLP stated that when in the building on 5/31/21 the nursing staff informed her they were looking into having the tracheostomy removed. The SLP stated the resident was removed from skilled care on 6/7/21 which was the last visit she made and

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F 695	Continued From page 24 while in the facility the suctioning equipment was located in a box in the resident's room. Review of the Progress Notes in the EHR showed the following entries: - On 8/4/21 at 6:32 PM Resident #25 continues to spew white foamy sputum. - Progress Note on 8/7/21 at 2:54 PM stated resident continues to spew white foamy sputum. - Progress Note on 8/8/21 at 6:19 PM stated the resident continues to spew white foamy sputum. - Progress Note dated 8/18/21 at 1:56 PM stated the resident seemed to have gurgles around 8:00 AM, upon auscultating, lung sounds were clear but resident remained to moan. Mouth was swabbed and orally suctioned, the contents were green/gray in color and thick. Progress Note dated 8/18/21 at 1:56 PM written by the Director of Nursing (DON) stated this nurse in with Licensed Practical Nurse (LPN) found resident to have thick brownish yellow mucus coming out the sides of her mouth. The resident is audibly gurgling even after oral suctioning. Upon taking off the tracheostomy cap, a large amount of brownish yellow mucus comes out of the tracheostomy. The resident is suctioned at this time and tolerates it well. Audible gurgling sounds are better. The provider was contracted and resident sent to the emergency room (ER). - Progress Note dated 8/24/21 at 6:28 PM stated a call was placed to Hospital for an update on Resident #25. The resident is waking up a little more, going to diuresis her and she still remains on the ventilator. During interview on 8/25/21 at 10:10 AM the NP A stated she was aware of the concerns from the SLP and talked to the DON about it. Stated she was informed from the DON that Resident #25	F 695		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165329	A. BUILDING _____ B. WING _____	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSLEY SPECIALTY CARE	305 WEST THIRD BOX 10 KINGSLEY, IA 51028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 25 was not being suctioned at the hospital so they didn't need to do it here. The NP A stated her assessments didn't show any concerns at the time but could not tell me when the last time she saw the resident. During interview on 8/25/21 at 11:47 AM the DON stated she did not feel Resident #25 needed to be suctioned because her trach was capped and the order for suctioning was PRN and the resident showed no signs of needing it. The DON stated the resident was not being suction in the hospital so why would she need to be suctioned here. When the DON was asked if trach care consisted of suctioning, she did not answer. During interview on 8/25/21 at 11:23 AM Staff I RN stated she never suctioned Resident #25. Staff I stated the DON was concerned about taking this resident and was pressured by the corporate office to take her and the DON told her she was concerned her staff could not take care of this resident. Staff I RN stated this was the first resident with a tracheostomy they had and nobody at the facility had ever taken care of one before. During interview on 8/25/21 at 10:27 AM with the Nurse Manager in Hospital taking care of Resident #25 she stated the resident is still currently on a ventilator and still requires suctioning throughout the day. She stated they have been suctioning her about 3-4 times a shift. During interview on 8/25/21 the Physician who is the Critical Care Specialist in charge of the care of Resident #25 for current hospitalization, when asked about the need for suctioning she stated at the minimum the resident should be suctioned	F 695		

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F 695	Continued From page 26 every 8 hours and more if needed. During interview on 8/25/21 at 12:27 PM with Staff M Registered Nurse (RN) who cared for the resident at the Hospital prior to admission to the nursing home stated they suctioned the resident at least once a shift and should be done as needed also. She stated the longest time staff should go without suctioning the resident is one shift if the patient is not needing it. When asked if the resident's trach could go three months without suctioning she stated Oh no, absolutely not, it should be done when trach care is being done at the least. Review of the Course Completion History for Trach/Tracheostomy Care Training, showed that 5 nurses at the nursing home received the training between the dates of 5/18/21 to 6/16/21. The remaining 5 nurses remained untrained in tracheostomy care. Review of the facility's Tracheostomy Care policy dated 1/2015 stated the purpose of tracheostomy care is to maintain patent airway, evacuate secretions, and to prevent and or reduce infection. The policy stated the suction equipment is needed and should be assembled at the bedside. The policy also stated documentation should include. date, time, color and consistency of secretions. Abatement: The facility was notified of the Immediate Jeopardy on 8/25/21 at 4:15 PM and given the IJ template at 4:25 PM. The Facility abated the immediate jeopardy on 8/25/20 by taking the following actions: 1. Upon admission and readmission of future	F 695		

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F 695	Continued From page 27 residents that would have a tracheostomy and need tracheostomy care, all nurses will be educated on tracheostomy care with competency performed prior to any care provided for that resident. 2. All admission orders are sent to the primary provider for review and signature. As of 7:00 PM on 8/25/21 all current nurses had completed Relias training on Tracheostomy and Trach Care and the scope and severity was lowered to a D.	F 695		
F 710 SS=E	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure a physician personally approved the admission orders in writing for 4 out of 4 residents reviewed, (Residents # 25, #8, #33	F 710	F710 Medical Services Residents are reviewed and seen by an MD on 9/16/2021. All residents have the potential to be affected. Education was provided that all residents that do not have an assigned MD will be reviewed upon admission for an appropriate provider status. New residents will be audited weekly for four weeks then one monthly time two months to include non-certified nurse aides with results of the audit forwarded to QAPI for further ~~recommendations if necessary~~ 09/24/2021	

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F 710	Continued From page 28	F 710		

and #19). The facility reported a census of 30 residents.

Findings include:

1. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/21 for Resident #25 showed resident to have a Brief Interview Status Score (BIMS) of 12 which indicated moderately impaireed cognitive skills. The resident had a diagnoses of paralytic syndrome following cerebral infarction, encounter for attention to tracheostomy, aphasia following cerebral infarction, dysarthria following cerebral infarction, and respiratory failure. The MDS showed the resident required total dependance of 2 staff for transfers, locomotion, and toilet use.

Review of the Electronic Health Record (EHR) showed the resident was admitted to the facility on 5/6/21.

Review of the Order Summary Report showed admission orders were approved by Nurse Practitioner A on 5/7/21.

2. The MDS with ARD of 6/17/21 for Resident # 8 showed the resident had a BIMS of 15 which indicated intact cognition. The MDS showed the resident had a diagnoses of anemia, hypertension, and muscle wasting. The resident was independent with transfers, ambulation and eating.

Review of the EHR showed the Resident #8 was admitted to the facility on 1/18/21.

Review of the Order Summary Report showed admission orders were approved by the physician

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F 710	Continued From page 29 assistant on 1/29/21. 3. According to the MDS with ARD of 8/12/21, Resident # 33 scored 11 on the BIMS which indicated moderate cognitive impairment. The resident had a diagnoses of dementia, pain in left hip and hypertension. The resident required extensive assistance with 1 staff for transfers, ambulation, and dressing. Review of the EHR showed Resident #33 was admitted to the facility on 2/25/21. Review of the Order Summary Report showed admission orders were approved by Nurse Practitioner B on 3/5/21. During interview on 8/29/21 at 12:46 PM the Director of Nursing stated that a physician does not come to see the residents that they are followed by a nurse practitioner (NP) or a physician assistant (PA) . She stated that they have the NP/PA sign all the orders. During interview on 8/29/21 at 2:48 PM the Administrator stated the facility lacks any policy that contains information on the Physician needing to sign admission orders and that they refer to the federal regulations for guidance. 4. The MDS dated 7/8/21 revealed Resident #19 needed the extensive assistance of 2 with bed mobility, transfers, and toileting and the limited assistance of 1 with eating. The resident's diagnoses included COVID-19, rheumatoid arthritis (painful swelling of the joints), hyponatremia (low amount of salt in the blood), hypertensive urgency (sudden increase in blood	F 710		

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F 710	Continued From page 30 pressure), retention of urine, Type 2 diabetes mellitus (high blood sugar level) with diabetic retinopathy (a complication of diabetes where vision is affected), cerebral infarction (stroke), blindness in right eye and low vision in left eye. The BIMS revealed Resident #19 had intact cognition. The resident's current Care Plan had focus areas to include I am at risk for falls, I am unable to transfer independently, I require staff assistance with my mobility related to weakness, gait imbalance, I am at risk for pressure ulcers, I use insulin/hypoglycemic medications related to diabetes, and I have a respiratory infection as evidence by a positive COVID-19 test. Resident #19's clinical record revealed that a nurse practitioner signed the resident's admission orders.	F 710		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician,	F 712	**F12 Physician Services** Residents are reviewed and seen by an MD on 9/16/2021. All residents have the potential to be affected. Education was provided to nursing staff that all residents will have an MD to be able to see them on the alternate visits nursing has been educated that there will have a calendar to monitor the visits. New residents will be audited weekly ~~for four weeks then one monthly time~~ two months to include non-certified	

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F 712	Continued From page 31 required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to make sure residents were seen by a physician at least once every thirty days for the first ninety days after admission, and at least once every sixty days thereafter for 4 out of 4 residents reviewed (Resident #25, #33, #8 and #19). Facility reports a census of 30 residents. Findings include: 1. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/21 for Resident #25 showed the resident had a Brief Interview Status Score (BIMS) of 12 which indicated moderate cognitive impairment. The resident had diagnoses of paralytic syndrome following cerebral infarction, encounter for attention to tracheostomy, aphasia following cerebral infarction, dysarthria following cerebral infarction, and respiratory failure. The resident required total dependence of 2 staff for transfers, locomotion, and toilet use. Review of the Electronic Health Record (EHR) showed Resident #25 was admitted to the facility on 5/6/21. Review of the Office Visit Notes showed the resident was seen by the Nurse Practitioner A on 5/7/21 for a new admission to the facility. The Visit Note was signed by the Nurse Practitioner A on 5/7/21 at 2:56 PM. The Nurse Practitioner saw	F 712	nurse aides with results of the audit forwarded to QAPI for further recommendations if necessary 09/24/2021	

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F 712	Continued From page 32 the resident again on 5/26/21 at 11:00 AM. The Nurse Practitioner saw the resident for the 60 day nursing home visit on 6/28/21 at 11:15 AM. Review of the Progress Notes showed the Nurse Practitioner visited Resident #25 on 7/16/21 at 4:25 PM. Review of the EHR lacked any documentation that Resident #25 was seen by a Physician since her admission on 5/6/21. 2. According to the MDS with ARD of 8/12/21, Resident # 33 scored 11 on the BIMS which indicated moderate cognitive impairment. The Resident had diagnoses of dementia, pain in left hip and hypertension. The Resident required extensive assistance with 1 staff for transfers, ambulation, and dressing. Review of the EHR showed Resident #33 was admitted to the facility on 2/25/21. Review of the Office Visit Notes showed the resident was seen by the Nurse Practitioner B on 3/4/21 at 2:30 PM through a telehealth visit. The Nurse Practitioner saw the resident again on 5/24/21 at 10:00 AM through a telehealth visit. The Nurse Practitioner saw the resident on 8/6/21 at 3:45 PM through a telehealth visit. Review of the EHR lacked any documentation that Resident #33 was seen by a Physician since her admission on 2/25/21. The EHR lacked documentation the resident had been seen for a 60 day nursing home visit. 3. The MDS with an ARD of 6/17/21 for Resident # 8 showed the resident had a BIMS of 15 which	F 712		

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F 712	Continued From page 33 indicated intact cognition. The MDS showed the resident had diagnoses of anemia, hypertension, and muscle wasting. Resident #8 was independent with transfers, ambulation and eating. Review of the EHR showed the Resident #8 was admitted to the facility on 1/18/21. Review of the Office Visit Notes showed Resident #8 was seen by the Physician Assistant (PA) on 2/11/21 at 9:20 AM through a virtual appointment. Review of the EHR lacked any documentation that Resident #8 was seen by a Physician since admission on 1/18/21. The EHR lacked documentation that the resident was seen for a 60 day nursing home visit, 90 day nursing home visit or continuing visits. During interview on 8/29/21 at 12:46 PM the Director of Nursing (DON) stated that a physician does not come to see the residents, that they have the Nurse Practitioner or the Physician Assistant sign all the orders and complete the visits. The DON stated she had the clinics send over all the Visits Notes, so if it's not there then she doesn't know when they were seen. The DON stated they do not track the physician visits. During interview on 8/29/21 at 2:48 PM the Administrator stated the facility lacked any policy that contains information on the Physician needing to sign admission orders and that they refer to the federal regulations for guidance. They refer to the federal regulation for guidance on frequency of physician visits and was handed a copy of the federal regulation F712 information.	F 712		

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F 712	Continued From page 34 Review of the F712 Federal Regulation supplied by the facility stated the resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. After the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist. Must be seen is defined as the physician or nurse practitioner must make actual face to face contact with the resident. F712 4. The MDS dated 7/8/21 revealed Resident #19 had a BIMS score of 15 which indicated intact cognition. The resident's diagnoses included COVID-19, rheumatoid arthritis (painful swelling of the joints), hyponatremia (low amount of salt in the blood), hypertensive urgency (sudden increase in blood pressure), retention of urine, Type 2 diabetes mellitus (high blood sugar level) with diabetic retinopathy (a complication of diabetes where vision is affected), cerebral infarction (stroke), blindness in right eye and low vision in left eye. The resident's current Care Plan had focus areas to include I am at risk for falls, I am unable to transfer independently, I require staff assistance with my mobility related to weakness, gait imbalance, I am at risk for pressure ulcers, I use insulin/hypoglycemic medications related to diabetes, and I have a respiratory infection as evidence by a positive COVID-19 test. Review of the resident's clinical record revealed that he has not had a visit from a physician since	F 712		

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F 712	Continued From page 35 his admission to the facility on 5/10/21.	F 712		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assesement required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure that a nurse aid	F 726	**F726 Administration** All new applicants for the nurse aide role did not have the proper training for the TNA waiver. All new employees that are not certified for the nurse aide could be reflected Education was completed with ADM, DON on the waiver and the needs for the course and competencies to be completed prior to the employee providing cares. New employees will be audited weekly for four weeks then one monthly time two months to include non-certified nurse aides with results of the audit forwarded to QAPI for further recommendations if necessary	09/24/2021

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F 726	Continued From page 36 demonstrated competency in skills and knowledge necessary to care for residents needs by making sure the employee completed the 8 hour training program required by the state of Iowa to obtain the certification of completion to become a temporary nurse aid. Findings include: Review of the employee time punch for Staff A Temporary Nurse Aid (TNA) showed staff A worked at the facility on 7/9/21, 7/12/21, 7/14/21, 7/16/21, 7/21/21, 7/22/21, 7/23/21, 7/28/21, 7/29/21, 8/2/21, 8/3/21, 8/4/21, 8/5/21, 8/7/21, 8/8/21, 8/9/21, 8/10/21, 8/11/21, 8/13/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/21/21, 8/22/21, and 8/23/21. Review of the employees file showed Staff A TNA to have completed the 8-hour Temporary Nurse Aid program on 8/23/21 and had a date of hire listed as 7/8/21. Review of the American Health Care Association (AHCA) website https://www.ahcancal.org, stated currently the 8-hour training program is permitted under special waiver, exceptions, or flexibilities for temporary nurse aid roles in the following states: Delaware, Indiana, Iowa, Maryland, Nebraska, New Jersey, New York, South Dakota, Texas, and West Virginia. Review of the Temporary Nurse Aid Skills and Competency Checklist stated it is to be used for new employees who completed the AHCA Temporary Nurse Aid training program to show competency. It stated that Center of Medicare Services (CMS) defines competency as a measurable pattern of knowledge, skills, abilities,	F 726		

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F 726	Continued From page 37 behaviors, and other characteristics that an individual needs to preform work roles or occasional functions successfully. During interview with Staff B Certified Nurses Aid (CNA) on 8/29/21 at 9:53 AM Staff B stated that Staff A TNA worked the day before yesterday as a CNA on the Covid hall. During interview with Staff C CNA on 8/29/21 at 10:06 AM Staff C stated that Staff A TNA worked last Friday as a CNA. During interview with Staff D CNA on 8/29/21 at 10:06 AM Staff D stated that Staff A TNA worked at the facility as a CNA and that she was a new CNA. During interview on 8/29/21 at 12:22 PM the Administrator stated she thought Staff A TNA had already taken the 8-hour temporary Nurse Aid training and once she discovered that she had not taken the class, Staff A was pulled from the floor and completed the class and obtained the certification of completion for the Temporary Nurse Aid. The Administrator stated that she does expect a TNA to complete the class before being allowed to work on the floor.	F 726		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812	**F 812 Food procurement, store/prepare/serve-sanitary** Kitchen was reviewed for cleanliness of the dish machine, light fixtures, walls and windows. Current residents have the potential to be affected. Kitchen Staff have been re-educated on the cleaning schedule and overall sanitation of the kitchen Kitchen will be audited weekly for four weeks then one monthly times two months with results of the audit forwarded to QAPI for further recommendations if necessary.	09/24/2021

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F 812	Continued From page 38 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and staff interview the facility failed to ensure a clean kitchen environment for food storage, preparation, and serving. The facility reported a census of 30 residents. Findings include: Observation on 8/23/21 at 11:41 AM revealed inside of the oven and range top with grime build up. Observation continued finding 3 sets of windows in the kitchen. All windows had a black substance on the windowsills, a white substance and dark substance in a splatter pattern on the inside of the windowpanes and windows screens. 1 set of windows had tinted film on the inside with film peeling off and a dead fly caught in the film. During the same observation a 2 switch, grooved light plate with dark grime was found. The Cleaning Instruction policy dated 2/16 revealed that all kitchen areas and equipment shall be maintained in a sanitary manner and be free of buildup of food, grease, or other soil.	F 812		

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F 880	Continued From page 40 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure appropriate infection control procedures related to the	F 880	**F 880 Infection Prevention and Control** Resident #4 was assessed related to improper catheter placement. Resident #4 assessed for outcomes from improper catheter placement Current incontinent residents have the potential to be affected. Clinical staff have been re-educated on providing proper catheter placement. All staff were reeducated on eye protection based on county positivity rate. Maintenance was verbally educated on proper COIVD protocol for barrier while survey was being completed. All staff was educated on screening of visitors and the need to take their temperatures and no self-screening All staff was educated on the clean laundry process to include keeping clean linen covered in the hallways.	

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F 812	Continued From page 39 In an interview on 8/23/21 at 11:08 AM, the Dietary Manager reported she did not think to look at the windows or switch plate for cleanliness. She admitted that the inside of the oven and range top did need a more thorough cleaning.	F 812	Three residents will be observed with catheter , 3 staff audits on eyewear, 3 audits on accushield screener, COVID isolation protocols will be audited weekly for four weeks then one monthly times two months with results of the audit forwarded to QAPI for further recommendations if necessary	09/24/2021
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		

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F 880	Continued From page 41 screening practice of staff entering the facility, catheter bag placement, oxygen tube changing, infection control practices and proper Covid-19 hall isolation. The facility reported a census of 30 residents. Findings include: 1. During observation on 8/23/21 at 3:17 PM the Foley catheter bag was located sitting on top of the Resident #4's bed under her feet. The Catheter policy dated 1/2015 stated to secure the drainage bag below the level of the bladder. During interview on 8/29/21 at 1:05 PM the Director of Nursing stated she expected the Foley bag be placed below the bladder to allow for drainage and not on top of the bed. 2. During observation on 8/23/21 at 9:30 AM it was communicated that 13 residents had tested positive for Covid-19 and were in isolation. When the Covid isolation hall was observed the door to hallway was opened and there was a small clear plastic shower curtain hanging in the middle of the hallway. The shower curtain had about 2 feet of open area around the sides to the wall and about 3 feet from the shower curtain to the floor was open area. Once the isolation hall was observed and the facility Administrator and Director Nursing (DON) were asked about the lack of isolation barrier between the Covid-19 positive residents and Covid-19 negative residents, the facility had maintenance put up a new plastic barrier that provided appropriate isolation.	F 880		

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F 880	Continued From page 42 3. Observation on 8/24/21 at 8:25 AM showed Resident # 34 had an oxygen concentrator in his room with a green oxygen tube attached. The oxygen tubing lacked any date. Review of the Treatment Administration Record (TAR) for the month of August for Resident #34 showed a lack of documentation that the oxygen tubing had been changed. During interview on 8/24/21 at 2:37 PM the DON stated the oxygen tubing gets changed every Sunday night and stated she thought the Certified Nurse's Aide (CNA) must have changed the tubing when they changed his room due to testing positive for Covid and that is why it was not dated. The DON then used the walkie to ask the CNA if they had removed the tubing and replaced it and forgot to date it and the CNA stated no it was the same tubing that was on in his other room. Review of the facility Oxygen Administration policy dated 1/2015 stated to check and change oxygen equipment and tubing per infection control manual. 4. During observation on 8/24/21 at 10:11 AM Staff G Licensed Practical Nurse (LPN) was at the nurse's station her eye protection on top of her head. Staff H, Registered Nurse (RN), was standing next to Staff G approximately 2 feet away giving Staff G shift report. During the same observation, Staff H pulled down her N95 face mask while talking on the telephone at the nurse's station. The facility Administrator pulled up Staff H's N95 face mask mask and directed Staff H to keep it pulled up at all times. Staff H	F 880		

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F 880	Continued From page 43	F 880		

responded to the Administrator that she cannot be heard by the people she talked on the phone with if she is wearing a face mask and it is pulled up to cover her mouth.

The Need for Eye Protection Clarified by DIA (Department of Inspections and Appeals) and IDPH (Iowa Department of Public Health) document dated 4/20/21 provided by the facility Administrator revealed that eye protection be worn by all health care employees as a protective source control when community transmission rates are considered to be high. The same document revealed that either a well-fitting facemask or a N95 respirator be worn by Health Care Providers (HCP) working in facilities located in areas with moderate to substantial community transmission.

In an interview on 8/30/21 at 1:16 PM, Staff O, Nurse Consultant, reported that the county positivity rate for COVID-19 was at the moderate level.

In an interview on 8/30/21 at 1:16 PM, the Director of Nursing (DON) reported she did not feel as though staff should wear eye protection when staff do work on the computer as it is difficult to see the computer screen while wearing eye protection. The DON did not provide an answer when asked if staff are not expected to wear eye protection when they are not socially distanced and giving verbal report.

In an interview on 8/30/21 at 1:16, neither the Director of Nursing (DON) or the facility Administrator would answer questions related to the need for staff to wear source control such as face masks or N95 face masks while in the

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F 880	Continued From page 44 facility. 5. During observation on 8/25/21 at 8:54 AM, Staff F answered the doorbell to answer the facility front door for a person to enter. Staff F did not take this person's temperature. Staff F resumed her housekeeping duties immediately after the person entered the facility. In an interview on 8/25/21 at 8:56 AM, Staff F reported she occasionally opens the door for people to enter facility and then immediately returns to her housekeeping duties without taking the temperature of the person entering the facility. The Screening Log Report from 8/1/21 to 8/24/21 contained a total of 869 entries. Forty two entries of those entries had verification of temperatures listed as myself, me, or self. The Accushield Kiosk - Signing In & Out document dated 9/23/20 directed people using the screening kiosk to enter your temperature and the name of the staff member who assisted. In an interview on 8/25/21 at 10:43 AM, the facility Administrator and the DON reported all staff have been trained to take the temperatures of those entering the facility in order to have verification of the manual temperature taken and that they would expect this procedure to be performed prior to entry into the facility. 6. Observation on 8/26/21 at 8:31 AM noted a clean linen cart in the 100 hallway open Observation on 8/26/21 at 8:31 AM the DON closed the clean linen cart.	F 880		

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F 880	Continued From page 45 During observation on 8/29/21 at 10:36 AM noted an open clean linen cart at the end of the 300 hallway in which the rooms of the residents infected with COVID-19 were located. The Laundry Policies: Infection Control dated 3/13 lacked information of the need for clean linen carts to be kept covered when they are in hallways. In an interview on 8/29/21 at 11:00 AM, Staff D, Certified Nurse Assistant (CNA) reported the clean linen cart should be closed. In an interview on 8/29/21 at 1:16 PM, the DON reported she would expect clean linen carts to be covered in hallways as part of infection control. 7. During observation on 8/25/21 at 11:25 AM, Staff I, Licensed Practical Nurse (LPN) knocked on Resident #2's door and entered. The resident reported she needed to use the commode. Staff I requested assistance with resident's request from Staff J, Certified Nurse Assistant (CNA). Staff I donned gloves without performing hand hygiene first, then opened drawers in the resident's room to locate the bag to line the commode container with. Staff I then changed gloves without performing hand hygiene. Staff J donned gloves without performing hand hygiene first. An EZ Stand lift was used to transfer the resident to the commode. Staff I and Staff J both doffed their gloves and Staff I washed her hands. Staff I directed Staff J to wash her hands and then Staff I left the room. Staff J washed her hands, turned the faucet off with her bare hands, shook her hands, and touched a washcloth hanging on a towel bar on right side of sink and put it back. Staff I entered the room with 3 paper towels and	F 880		

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F 880	Continued From page 46 gave them to Staff J. Staff J then dried her hands before donning gloves. Staff I washed hands, turned the faucet off with her bare hands and directed Staff J to use her walkie talkie to request paper towels. Staff I then donned gloves. Staff I performed peri care to clean resident after toileting. Staff J applied a new disposable incontinence brief to resident while Staff I washed her hands. Staff I turned the faucet off with her bare hands and donned gloves. Paper towel were delivered to the room at 11:49 AM. The resident was transferred to her recliner with Staff I and Staff J using the EZ Stand. Staff I and Staff J doffed their gloves and washed their hands. The Handwashing policy dated 4/18 directed hand washing be performing after removing gloves. The Gloves policy dated 4/18 revealed handwashing is necessary even if gloves are used. In an interview on 8/26/21at 2:26 PM, the DON, who was also the infection prevention control nurse for the facility reported she would expect hand hygiene would be performed with glove changes, before donning gloves, and after touching inanimate items in a resident's room that are likely to be touched frequently. In the same interview, the DON reported staff should have hand sanitizer in their pockets and that resident rooms should be well stocked with paper towels.	F 880		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(l)(4) §483.90(l)(4) Maintain an effective pest control program so that the facility is free of pests and	F 925		

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F 925	Continued From page 47 rodents. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and staff interview the facility failed to ensure the kitchen was free from pests. The facility reported a census of 30 residents. Findings include: Observation on 8/23/21 at 10:38 AM revealed rodent droppings in a kitchen cabinet. The facility Pest Control policy dated 2/16 revealed that a pest control contractor completes preventative treatments at prescheduled times. In an interview on 8/23/21 at 11:08 AM, the Dietary Manager reported that she did not know rodent droppings were in the cabinet and that she would add cleaning this cabinet to the cleaning list. In an interview at 8/25/21 on 2:28 PM, the Administrator reported that there is a pest control service contracted to provide services to the facility.	F 925	**F 925 Effective Pest Control** Kitchen is identified with pests have been cleaned and sprayed for pests. Current residents have the potential to be affected. Pest control is set up on a routine visit. Staff have been re-educated on how and where to report pests sightings in the facility. Kitchen will be audited weekly for four weeks then one monthly times two months to include bathrooms and common use areas for sightings of pests with results of the audit forwarded to QAPI for further recommendations if necessary.	09/24/2021